OCCUPATIONAL MEDICAL SERVICES
OFFICE OF HUMAN RESOURCES
MONTGOMERY COUNTY, MARYLAND
INTERVAL MEDICAL HISTORY FORM

LAST NAME | FIRST NAME | MIDDLE NAME | TODAY'S DATE

POSITION TITLE: | SUPERVISOR'S NAME & PHONE:

DEPARTMENT: | WORK SITE:

HOME ADDRESS:
Street:
City:
State: Zip Code:

HOME PHONE | SEX

WORK PHONE | DOB

PURPOSE OF EXAM:
Return to Work _____ Work Related_____ Non-Work Related _____
Periodic _____ Fitness For Duty _____ Light Duty _____ Other_____

Name, Address, and Phone of Personal Health Care Provider:

Yes	No	
( )	( )	Have you seen any Physician, Psychiatrist, or other Health Care provider for evaluation or treatment since your last visit here? If yes, please complete the following: Date Name and Address of Health Care Provider Reason for Visit
( )	( )	Have you missed more than 3 consecutive days of work due to illness or injury since your last visit here? If yes, complete the following: Date Number of Days Missed
( )	( )	Are you currently on restricted duty? If yes, please state type of restrictions, reason, and earliest date your Health Care Provider has advised you may be able to return to full, unrestricted duty:
( )	( )	Do you currently have any claims pending for Workman's compensation Disability? If yes, please give details, including nature of injury, date of injury, and name and address of the Health Care Provider treating you.
( )	( )	Do you currently have an application or appeal pending for Disability Retirement? If yes, please give details including nature of condition, date of application, and name and address of physician treating you.

(OVER)

Yes ( ) No ( ) Are you currently on any prescribed or over the counter medications or special diets? If yes, complete the following:

Name of Medication or Diet	Purpose	Name and Address of prescribing physician/ nurse practitioner:

Yes ( ) No ( ) Do you have any additional information regarding your health which you wish to make a part of your permanent health record? If yes, give details below:

Yes ( ) No ( ) Are you currently in good health to the best of your knowledge and belief? Make any comments below:

Yes ( ) No ( ) Are you currently a volunteer for a Montgomery County Fire Corporation?

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the Health Care Providers, hospitals or clinics mentioned above to furnish the Employee Medical Examiner of Occupational Medical Services a complete transcript of my medical record for purposes of evaluating fitness for duty or other work-related health issues if necessary.

Signature _____ Date _____

Social Security # _____

Physician or Nurse Practitioner Summary and Comments On All Pertinent Data:

Date _____ Signature _____